DEPARTMENT OF HEALTH AND HU PRINTED: 09/24/2008 N SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING C B. WING 297082 06/06/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SAGUARO HOME HEALTH CARE 2770 S MARYLAND PKWY, SUITE 215 LAS VEGAS, NV 89109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE T# 3 **DEFICIENCY**) G 000 INITIAL COMMENTS G 000 This Statement of deficiencies was generated as a result of the Medicare re-certification survey investigation conducted at your agency on June 6, 2008. The active census at the time of the survey was 163. Fifteen clinical records were reviewed. Five home visits were conducted. The following four complaints investigated at the time of the survey: CPT #NV12150 - Unsubstantiated CPT #N√18336 - Substantiated (Tag G158) CPT #NV15635 - Unsubstantiated CPT #NV17877 - Substantiated(Tag G158) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified. G 143 484.14(a) COORDINATION OF PATIENT G 143 **SERVICES** All personnel furnishing services maintain liaison RECEIVED to ensure that their efforts are coordinated effectively and support the objectives outlined in UCT 8 7 Mgg the plan of care.

liaison so that their efforts supported the plan of care in 2 of 15 records reviewed (#3, #9).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure staff providing services maintained

TITLE

(X6) DATE

ADMINISTRATOR

10/6/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			CONSTRUCTION	(X3) DATE S COMPLE	
		227000	B. WIN		3			С
		297082	15. ***	_			06/0	6/2008
	PROVIDER OR SUPPLIER RO HOME HEALTH CA	ARE		27	770 S	ADDRESS, CITY, STATE, ZIP CODE S MARYLAND-PKWY, SUITE 215 /EGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 143	Continued From pa	ge 1	G 1	143	G14	43		
	Findings include: Patient #3				A.	There is no corrective action pla patients 3 and 9 because they hadischarged.		10/29/08
	diagnoses Congest	nitted on 1/7/07 with the ive Heart Failure, Encounter Monitor, Glaucoma and Gait	ļ	,	B.	The agency will identify others the potential to be affected. Che will be made weekly for all pati including Start of Care, Resump Care, Recertifications, and Disc	art audits ients ption of	10/29/08
	Record Review Physician's orders, dated 11/8/07 through 1/6/08 revealed: "Physical therapy evaluation for				C.	In addition to B, the agency will other measures such as hiring at consultant and educating and traclinical staff.	n RN	10/29/08
1974	conducted and the f	vsical therapy evaluation was following plan of care was			D.	The agency will monitor the proits corrective action plan by per chart audits. See B.		10/29/08
	established to provi 2 week 5."	de physical therapy "1week 1;			E.	The person responsible for com assurance is the QA Coordinato		10/29/08
ļ	summary document maximum rehabilita instructed to continu program and follow to follow up with MD instructed to call for	nysical therapist discharge ted: "the patient had reached ition potential. The patient ue with home exercise rest/activity schedule. Needs (medical doctor) and appointment. Instruct to urse for change in functional				RECEIV	/FD	
	skilled nurse was no	was no documented evidence to verify the nurse was notified at the time of discharge hysical therapy services.				OCT 0 7 2	2008	
	Patient #9					LAS YEGAS, NEVA	iDA	
		s 2/22/08 with the diagnoses Pulmonary Disease with						

	OF CORRECTION	IDENTIFICATION NUMBER:	1, ,	ILDING	LE CONSTRUCTION		COMPLE	ETED
		297082	B. WIN	√G				C 6/2008
	PROVIDER OR SUPPLIER	ARE		27	ET ADDRESS, CITY 70 S MARYLAND - IS VEGAS, NV 8		33,0	0,200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORR	R'S PLAN OF CORRECTIVE ACTION SHO ENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 158	Asthma, Congestive Weakness, and River Record Review Physician's orders, "Occupational Theorem Congression of the Patient Pati	dated 2/22/08, revealed: rapy evaluation for weakness." cupational therapy assistant ent to a family member with ras no documented evidence ational threapy assistant et of the plan for discharge. NCE OF PATIENTS, POC, en plan of care established riewed by a doctor of medicine,	G 1	7,000	patients # 1, have been di B. The agency the potential will be made including St Care, Recert C. In addition t other measu consultant a clinical staff D. The agency its corrective chart audits.	will identify other to be affected. Ce weekly for all part of Care, Resuntifications, and Disto B, the agency were such as hiring and educating and to f. will monitor the peraction plan by pe	certification and a color of cause they are having thart audits attents anption of scharge. Till institute an RN training the corogess of erforming	10/29/08 10/29/08 10/29/08
Genera	Generalized Weaki Arthritis.	alized Weakness, and Rheumatoid				responsible for con the QA Coordinat		10/29/08
	Record Review							
				1				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		297082	B. WI	1G _			C 6/2008
	PROVIDER OR SUPPLIER	ARE		2	REET ADDRESS, CITY, STATE, ZIP CODE 770 S MARYLAND PKWY, SUITE 215 AS VEGAS, NV 89109	1 30,00	0.200
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 158	"Skilled nurse to vis times a week for eigen week for one week provide services state for seven weeks." The skilled nurse convects starting on 3 not comply with the comply with the season of the last documents on 3/10/08. There we health aide visit corrordered by the physical Patient #8 Patient #8 was admidiagnoses of Ortho Mellitus, Neuropath Fatigue. Record Review On 5/16/08, the occa visit. There was meaning the season of the physical patient was not set to season on the season of the physical patient was admidiagnoses of Ortho Mellitus, Neuropath Fatigue.	lers, dated 2/22/08 revealed: sit 1 time a week for 1 week; 2 ght weeks and one time a . The home health aide to arting 3/1/08 two times a week onducted one visit during the 8/1/08 and 4/12/08, which did a physician's orders. ed home health aide visit was was no documented home inducted two times a week as	G	158			
	Patient #10 was ad following diagnoses	mitted on 2/4/08 with the s: Cerebrovascular Accident, tory of Falls, Atrial Fibrillation, us.			RECE OCT O BUREAU OF LICENSUR LAS YEGA	7 2008 E AND CERTIFICATION	
	The physician's ord	ers dated 2/4/08 through					
	· · · · · · · · · · · · · · · · · · ·	-					I .



	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		IG	COMPLE	
		297082	B. WII	NG _			6/2008
	ROVIDER OR SUPPLIER	ARE		2	REET ADDRESS, CITY, STATE, ZIP COD 1770 S MARYLAND PKWY, SUITE 21 LAS VEGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 158	4/3/08, indicated: "Stimes a week for 3 weeks." During the week stadocumented evider conducted a home On 2/9/08, the physical therapy evestablished on 2/9/06 to visit 2 times a wefor 7 weeks." The physical therapy during the week staper the physician's conducted one hom starting on 2/23/08 the physician's ordeconducted two hom starting on 3/15/08, the physician's ordeconducted two hom starting ordeconducted two hom starting ordeconducted two hom starting ordeconducted two hom starting ordeconducted two h	Skilled Nursing to visit patient 2 weeks, 1 time a week for 6 arting 3/29/08, there was no nee to verify a skilled nurse visit. Sical therapist conducted a aluation. The plan of care 08 indicated: "physical therapy eek for 1 week; 3 times a week of the physical therapist arting on 2/16/08, not three as order. The physical therapist he visit during the week not three visits according to ers. The physician therapist he visits during the week not three visits according to	G	158			
	conducted 1 home physician's order. D 4/12/08, the skilled	weeks." arting 4/5/08, the skilled nurse visit, not 2 according to the During the week starting on nurse conducted 1 sits according to the			OC RINGFALL OF L	CEIVED T 0 7 2008 CENSURE AND CERTIFICA IS YEGAS, NEVADA	
		arting 5/10/08, the CNA visit, not 3 home visits as per					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297082	B. WIN	IG		- 1	C 6/2008
	ROVIDER OR SUPPLIER	ARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S MARYLAND PKWY, SUITE 215 LAS VEGAS, NV 89109				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 158	the physician's order 5/17/08, the CNA or home visits as per Patient #6 The start of care widiagnoses: Non Instruction Hypertension, Antic General Weakness The physician's order 6/2/08, indicated: "3 times a week for 2 weeks." During the week stanurse conducted 1 the physician's order 1 the physician's order 2 weeks." During the week stanurse conducted 1 the physician's order 2 was conducted 2 the physician's order 2 was conducted 2 the physician's order 2 was conducted according to the week stanurse conducted according to the physician's order 2 was conducted according to the physician's order 2 weeks."	er. During the week starting conducted 1 home visit, not 3 the physician's order. as 4/4/08 with the following sulin Diabetes Mellitus, coagulant Therapy, and s. ders dated 4/4/08 through Skilled Nurse to visit patient 2 weeks, 1 time a week for 7 arting 4/12/08, the skilled home visit not 2 according to er. arting 4/26/08, there was no noce a skilled nursing home visit cording to the physician's order.	G ·	158			
		g Cervical Spine Stenosis, pertension, Status Post Lumbar				CEIVE	
	Record Review					T 0 7 2008	
	through 3/11/2008,	ian's orders dated 1/12/2008 indicated: "Skilled Nursing to a week for 2 weeks, 1 time a			BUREAU OF LI	CE CAR BRUSHBD ABAYBA BABBY B	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		297082	B. WIN	IG			5 6/2008
	ROVIDER OR SUPPLIER	ARE		27	EET ADDRESS, CITY, STATE, ZIP CODE 770 S MARYLAND PKWY, SUITE 215 AS VEGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 158	Continued From pa	age 6	G 1	58			
	and 3/11/2008. The evidence that phys decrease skilled nu. There was no docuphysician was cont	visits were made on 1/12/2008 ere was no documented ician orders were made to ursing visits for Patient #1. Immented evidence that the acted regarding missed SN between 1/12/2008 through					
		ian's orders dated 3/12/2008 indicated: "SN to visit patient 9 weeks."					
	One SN visit was n 4/25/2008 and wee	nade for week ending k ending 5/2/2008.					
		mented evidence to decrease veek for weeks ending k ending 5/2/2008.					
	physician was cont	mented evidence that the acted regarding missed skilled atient #1 for weeks ending 2008.					
	Interview						
	indicated that Patie registered nurse (R licensed practical n The office manage do any visits for Pa confirmed that the	afternoon, the office manager on #1's case was opened by a (N) and then transferred to a curse (LPN) by the scheduler. In the indicated that the LPN did not tient #1. The office manager physician's orders, dated 3/11/2008 and 3/12/2008 were not followed.			OCT BUREAU OF LICENS	EIVED 0 7 2008 SURE AND CERTIFICAT GAS, NEVADA	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297082	B. WIN			1	С
NAME OF F	PROVIDER OR SUPPLIER	201002		STR	EET ADDRESS, CITY, STATE, ZIP CODE	06/0	6/2008
SAGUAF	RO HOME HEALTH CA	ARE			770 S MARYLAND'PKWY, SUITE 215 AS VEGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 158	· · · · · · · · · · · · · · · · ·		G 1	58			
G 159	Complaint #NV1787 484.18(a) PLAN OF		G 1	150	G159		
J .55	The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury,			33	A. There is no corrective action pl patients 3 and 15 because they discharged.		10/29/08
					B. The agency will identify others the potential to be affected. Ch will be made weekly for all pat including Start of Care, Resum Care, Recertifications, and Disc	nart audits ients ption of	10/29/08
ĺ	instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by:		Į	C. In addition to B, the agency wi other measures such as hiring a consultant and educating and to clinical staff.	ın RN	10/29/08	
	Based on interview a failed to revise goals certification period to	and record review, the agency s on the plan of care from coertification period teaching	¥3		D. The agency will monitor the prits corrective action plan by perchart audits. See B.		10/29/08
	(#3, #15).	or 2 of 15 sampled patients		-	E. The person responsible for com assurance is the QA Coordinate		10/29/08
	Findings include:			-			i
	Patient #3			ŀ		(8	
	Congestive Heart Fa	tted on 1/7/07 with diagnoses illure, Encounter Therapeutic oma and Gait Abnormality.					
	Record Review				Sin. m		
		07, 12/19/07, 1/19/08, 2/1/08, d 4/28/08, the skilled nurse				CEIV	
	assessed and documpatient to care and heart Disease. The	nented the responses of ealth teaching for Congestive patient was unable to give y to answer questions.			BUREAU OF LI	T 0 7 20 CENSURE AND CER AS VEGAS, NEVADA	

- 1 · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		297082	B. WI	NG _			6/ 2008
	ROVIDER OR SUPPLIER	ARE		2	REET ADDRESS, CITY, STATE, ZIP CODE 770 S MARYLAND PKWY, SUITE 215 AS VEGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
G 159	"Patient hasn't take was administered a Patient complaining of living at senior liv was reinforced in di Signs and symptom process of Congest On 5/8/08, the skille stated that patient of drinking. Patient live and needs to go do instructed in small of prevent from dehydrometric on 5/13/08, the skille "Patient was instructed in Signs and Na (sodium) Adequate dehydration. Complailure." On 5/20/08, the skille "Patient forgot taking breakfast and lunch oral medications. In meals; adequate fludehydration. Patient	illed nurse documented: en oral medications. Patient all oral medications for today. g of poor appetite. Frustration ving. Vital signs taken. Patient isease process of dehydration. ns of dehydration and disease tive Heart Failure." ed nurse documented: "Patient didn't feel like eating and es at senior/ assisted living ownstairs. Patient was frequent meals. push fluid to	G	159			
	Observation						
	was only a small sir resident's room. Th the residents' room	visit was conducted. There nk and refrigerator in the nere was no cooking allowed in is.				OCT 0 7 OF LICENSURE AND LAS YEGAS. NEVA	2008 CERTIFICATION
	Interview					DAJ TEGAJ, RETA	
	On 6/4/08, an inten	view with the skilled nurse and					

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		297082	B. WING		1	C 6/2008	
	ROVIDER OR SUPPLIER	ARE	S	TREET ADDRESS, CITY, STATE, ZI 2770 S MARYLAND PKWY, SUI LAS VEGAS, NV 89109	P CODE	0/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 159	indicated the patier arranged the weekl independent living to daily. The staff who not contact residen The skilled nurse doinstruction on the posteach a confused posteach according to the patient #15 The start of care was Diabetes Mellitus, Hatrial Fibrillation, Most Record Review The physician's ord "Skilled nursing to weeks, and 1 time as During the week stanurse conducted two according to the physician's to the ph	atted. The skilled nurse atts son, who was a physician, y medication box. The facility prepared three meals worked at the living facility did ats at meal times. Eveloped the goals for lan of care and continued to atient as 4/28/08 with the diagnoses dypertension, Osteoarthrosis, alaise and Fatigue. Ers dated 4/28/08, revealed: Arisit 3 times a week for 3 are week for 3 weeks." Arting 4/22/08, the skilled to home visits, not three	G 15				
	Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.		A. There is no corrective patients 3 and 8 becaudischarged.B. The agency will ident the potential to be affectively be made unabled.	ify others having ected. Chart audits	10/29/08		
·	This STANDARD is not met as evidenced by: Based on record review, the agency staff failed to alert the physician about a discharge and a change in the plan of care for 2 of 15 sampled patients (#3, #8).			will be made weekly to including Start of Care Care, Recertifications	e, Resumption of		

PRINTED: 09/24/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
!		A. BUILD			С
	297082	B. WING		06/0	6/2008
			2770 S MARYLAND PKWY, SUITE 21 LAS VEGAS, NV 89109	5	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
Patient #3 Patient #3 was admidiagnoses of Conge Therapeutic Drug Mahnormality. Record Review Physician's orders or revealed: "Physical unsteady gait and worked and the festablished to provide week 5." On 12/29/07, the physical unstructed to continue program and follow to follow up with MD	dated 11/8/07 through 1/6/08 therapy evaluation was following plan of care was de physical therapist discharge ted: "the patient had reached ation potential. The patient ue with home exercise rest/activity schedule. Needs of (medical doctor) and	G 164	 G164 C. In addition to B, the agency other measures such as hir consultant and educating a clinical staff. D. The agency will monitor the its corrective action plan by chart audits. See B. E. The person responsible for 	ing an RN and training the see progess of y performing compliance	10/29/08
There was no docur physician was notific from physical therap Patient #8 The start of care wa	mented evidence to verify the ed at the time of discharge by services .				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From par Findings include: Patient #3 Patient #3 was adm diagnoses of Conge Therapeutic Drug M Abnormality. Record Review Physician's orders of revealed: "Physical unsteady gait and w On 11/8/07, the phy conducted and the f established to provid 2 week 5." On 12/29/07, the ph summary document maximum rehabilitat instructed to continu program and follow to follow up with MD instructed to call for report to MD and nu status." There was no docur physician was notifie from physical therap Patient #8 The start of care wa	RO HOME HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 Findings include: Patient #3 Patient #3 was admitted on 1/7/07 with the diagnoses of Congestive Heart Failure, Encounter Therapeutic Drug Monitor, Glaucoma and Gait Abnormality. Record Review Physician's orders dated 11/8/07 through 1/6/08 revealed: "Physical therapy evaluation for unsteady gait and weakness." On 11/8/07, the physical therapy evaluation was conducted and the following plan of care was established to provide physical therapy "1 week 1; 2 week 5." On 12/29/07, the physical therapist discharge summary documented: "the patient had reached maximum rehabilitation potential. The patient instructed to continue with home exercise program and follow rest/activity schedule. Needs to follow up with MD (medical doctor) and instructed to call for appointment. Instruct to report to MD and nurse for change in functional status." There was no documented evidence to verify the physician was notified at the time of discharge from physical therapy services.	PROVIDER OR SUPPLIER RO HOME HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 Findings include: Patient #3 Patient #3 was admitted on 1/7/07 with the diagnoses of Congestive Heart Failure, Encounter Therapeutic Drug Monitor, Glaucoma and Gait Abnormality. Record Review Physician's orders dated 11/8/07 through 1/6/08 revealed: "Physical therapy evaluation for unsteady gait and weakness." On 11/8/07, the physical therapy evaluation was conducted and the following plan of care was established to provide physical therapy "1 week 1; 2 week 5." On 12/29/07, the physical therapist discharge summary documented: "the patient had reached maximum rehabilitation potential. The patient instructed to continue with home exercise program and follow rest/activity schedule. Needs to follow up with MD (medical doctor) and instructed to call for appointment. Instruct to report to MD and nurse for change in functional status." There was no documented evidence to verify the physician was notified at the time of discharge from physical therapy services. Patient #8 The start of care was 5/15/08 with diagnoses of	ROUDER OR SUPPLIER RO HOME HEALTH CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 Findings include: Patient #3 Patient #3 was admitted on 1/7/07 with the diagnoses of Congestive Heart Failure, Encounter Therapeutic Drug Monitor, Glaucoma and Gait Abnormality. Record Review Physician's orders dated 11/8/07 through 1/6/08 revealed: "Physical therapy evaluation for unsteady gait and weakness." On 11/8/07, the physical therapy evaluation was conducted and the following plan of care was established to provide physical therapy "1 week 1; 2 week 5." On 12/29/07, the physical therapist discharge summary documented: "the patient had reached maximum rehabilitation potential. The patient instructed to call for appointment. Instruct to report to MD and nurse for change in functional status." There was no documented evidence to verify the physician was notified at the time of discharge from physical therapy services. Patient #8 The start of care was 5/15/08 with diagnoses of	PROVIDER OR SUPPLIER RO HOME HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE (REGULATIORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 Findings include: Patient #3 Patient #3 was admitted on 1/7/07 with the diagnoses of Congestive Heart Failure, Encounter Therapeutic Drug Monitor, Glaucoma and Gait Abnormality. Record Review Physician's orders dated 11/8/07 through 1/6/08 revealed: "Physical therapy evaluation for unsteady gait and weakness." On 11/8/07, the physical therapy evaluation was conducted and the following plan of care was established to provide physical therapy "1 week 1; 2 week 5." On 12/29/07, the physical therapist discharge summary documented: "the patient had reached maximum rehabilitation potential. The patient instructed to cell for appointment. Instruct to report to MD and nurse for change in functional status." There was no documented evidence to verify the physical was notified at the time of discharge from physical therapy services. Patient #8 The start of care was 5/15/08 with diagnoses of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0Y3711

Facility ID: NVS606HHA

If continuation sheet Page 11 of 15

PRINTED: 09/24/2008 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUC		COMPLETED C				
		297082	B. WIN	IG			6/2008
	ROVIDER OR SUPPLIER	ARE		27	EET ADDRESS, CITY, STATE, ZIP COE 70 S MARYLAND PKWY, SUITE 21 AS VEGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 164	Neuropathy in Diab and Fatigue. Record Review On 5/16/08, the phy indicated: "Physica Patient went to nea 5/19/08 for schedu Called again 5/21/0 Await patient's retu week." There was in verify the physical to about the change in 484.18(c) CONFOR ORDERS Drugs and treatme agency staff only and This STANDARD in Based on interview failed to ensure that administered by agent that administered by ag	ysical therapy assistant I therapy three times a week. In by state on Monday night led prosthetic fitting 5/20/08. It and patient not back in town. In to complete visits this no documented evidence to therapist notified the physician in the plan of care. RMANCE WITH PHYSICIAN Into are administered by Is ordered by the physician. Is not met as evidenced by: I and record review, the agency It treatments were ency staff only as ordered by of 15 sampled patients (#4, Intitled on 5/10/2008 with It is not met as evidenced by I and record review, the agency It treatments were I and record review, the agency I treatments were I and record review, the agency I treatments were I and record review, the agency I treatments were I and record review, the agency I treatments were I and record review, the agency I and record review, the agency I treatments were I and record review, the agency I	G 1	165	G165 A. There is no corrective action patients number 4, 14, and 3 have been discharged. B. The agency will identify out the potential to be affected. will be made weekly for all including Start of Care, Res Care, Recertifications, and 3. C. In addition to B, the agency other measures such as hiring consultant and educating an clinical staff. D. The agency will monitor the its corrective action plan by chart audits. See B. E. The person responsible for assurance is the QA Coordinate of the coordinate of th	ners having Chart audits patients cumption of Discharge. will institute ing an RN ind training the e progess of performing compliance	10/29/08 10/29/08 10/29/08 10/29/08
	I ne plan of care es	stablished on 5/10/2008					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0Y3711

Facility ID: NVS606HHA

If continuation sheet Page 12 of 15



PRINTED: 09/24/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` ′	IULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		297082	B. WII	NG		06/	06/2008
	ROVIDER OR SUPPLIER	ARE		277	ET ADDRESS, CITY, STATE, ZIP CODE O S MARYLAND PKWY, SUITE 215 S VEGAS, NV 89109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 165	indicated "Skilled N 5/10/2008 to 5/19/2 Daily SN visits were 5/18/2008 and conf 6/1/2008. There was no docudaily SN visits after #4. Patient #14 Patient #14 was addiagnoses including weakness and oster Record Review On 3/13/2008, the producted a PT event and 2 times a week for 4. After the 4th week ovisit Patient #14 throw and 2 times a week documented visit of documented evider was obtained to conweek. Patient #8 The start of care was Orthopedic Aftercal	lursing (SN) to visit daily from 2008." e made from 5/10/2008 to cinued from 5/20/2008 to mented evidence to continue 5/18/2008 for Patient mitted on 3/8/2008 with gait abnormality, generalized coarthritis. chysical therapist (PT) aluation. The plan of care 8/2008 indicated "PT to visit 3	G	165			
	and Fatigue.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0Y3711

Facility ID: NVS606HHA

If continuation sheet Page 13 of 15



PRINTED: 09/24/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		297082	B. WING				C 06/06/2008	
NAME OF PROVIDER OR SUPPLIER SAGUARO HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S MARYLAND PKWY, SUITE 215 LAS VEGAS, NV 89109				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 169	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			EFIX (EACH CORRECTIVE ACTION AG CROSS-REFERENCED TO THE		he patient had hers having Chart audits patients sumption of Discharge. will institute ng an RN nd training the	10/29/08 10/29/08 10/29/08	
	On 6/6/2008 in the a	afternoon, the office manager						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0Y3711

Facility ID: NVS606HHA

If continuation sheet Page 14 of 15





STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
		297082				C		
NAME OF PROVIDER OR SUPPLIER SAGUARO HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S MARYLAND PKWY, SUITE 215 LAS VEGAS, NV 89109				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
G 169	Continued From page 14 indicated: "(Patient #1's) case was started by a registered nurse (RN) on 3/13/2008 and then transferred to a licensed practical nurse (LPN) by the scheduler." The office manager confirmed that the LPN did not do any visits for Patient #1 from 1/12/2008 through 3/11/2008. Record Review		G 1	169				
	through 3/11/2008, visit patient 2 times week for 7 weeks." Skilled nursing (SN 1/12/2008 and 3/11 documented evide	ian's orders dated 1/12/2008 indicated: "Skilled Nursing to a week for 2 weeks, 1 time a l) visits were made on 1/2008. There was no ence that physician orders were skilled nursing visits for Patient						
	physician was cont visits for Patient #1 3/11/2008. Patient #1's case w 3/12/2008 and ther scheduler. There w that the assigned F not visit Patient #1	imented evidence that the facted regarding missed SN between 1/12/2008 through was started by a RN on a transferred to a LPN by the was no documented evidence RN was aware that the LPN did and the RN supervised the 8 through 3/10/2008.						